DR. HODGES

Within corporate limits

M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06300

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY: ALLEGANY CUMBERLAND MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: [redacted] Michigan COUNTY: Genesse [redacted]
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 6 hrs. 10 min.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: [redacted] Flint
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): [redacted] 701 Begole St.

3. NAME OF DECEASED (Type or Print) (First) BABY (Middle) BOY (Last) ALLAN			4. DATE OF DEATH (Month) 7 (Day) 11 (Year) 1949		
5. SEX: M	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE	8. DATE OF BIRTH: 7-11-49	9. AGE last bi[illegible] yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours 6 / Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME: ALLAN, EDWARD R. JR.		14. MOTHER'S MAIDEN NAME: HOUSE, MARYLAND H.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: MEMORIAL HOSPITAL, MEMORIAL AVE.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Atelectasis	7 hrs
762.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Prematurity	6 1/2 m.
159	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) — (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☑	HOW DID INJURY OCCUR? —	

22. I hereby certify that I attended the deceased from July 11, 1949, to July 11, 1949, that I last saw the deceased alive on July 11, 1949, and that death occurred at 7:00P m. from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
W Royce Hodges, M.D.	Cumberland, Md.	7/12/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 13 49	Mt Pleasant Cem	Allegany Co Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 13, 1949	Winter R. Frantz, M.D.	Louis Stein Inc	Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
JUL 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06301

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 1 day	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.D. Lonaconing
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital	STREET ADDRESS (If rural, give location) None

3. NAME OF DECEASED (Type or Print)	(First) George	(Middle) —	(Last) Allen	4. DATE OF DEATH (Month) July	(Day) 3	(Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	July 17 1893	55 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner	Coal Mine	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Allen	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	214-01-6705	Mrs. Allen

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Alcoholism — Acute	6 wks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

322.0 77c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While ~~at~~ Work ☐ ~~Not~~ While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7/4, 1949, to 7/7, 1949, that I last saw the deceased alive on 7/4, 1949, and that death occurred at ....m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul Eugene Dye	M.D	Lonaconing Md.	7/7/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 6 '49	Oak Hill Cemetery	Lonaconing Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-7-49	Mrs. Blanche O. Price Acting	M. E. Ichhorn	Lonaconing Md.

VS. A15

RECEIVED
JUL 8 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

DR. HODGES

2411 N. Charles Street, Baltimore

06302

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. | LENGTH OF STAY (In this place) 7 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA — COUNTY MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KEYSER
STREET ADDRESS (If rural, give location) 47 SHARPLESS STREET

3. NAME OF DECEASED (Type or Print): (First) Crystal (Middle) (Last) ALT

4. DATE OF DEATH: (Month) JULY (Day) 31 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: JULY 24, 1949

9. AGE last birthday: yrs. — If under 1 year: Months / Days 7 DAYS — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL ALT

14. MOTHER'S MAIDEN NAME: NORMA J. PENNINGTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Partial separation of placenta

761.5, 160a

(c)

INTERVAL BETWEEN ONSET AND DEATH: 6 Mon ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 24, 1949, to July 31, 1949, that I last saw the deceased alive on July 30, 1949, and that death occurred at 4:03 A. m., from the causes and on the date stated above.

SIGNATURE W R Joyce Hodges (Degree or title) ADDRESS Cumberland, MD. DATE SIGNED 7/31/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF July 31, 1949 — NAME OF CEMETERY OR CREMATORY Queens Point — LOCATION (City, town, or county) Keyser — (State) W Va

DATE REC'D BY LOCAL REG. July 31, 1949 — REGISTRAR'S SIGNATURE Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR Thomas A Smith Jr — ADDRESS Keyser W Va

#754

VS. A15

RECEIVED
AUG 4 1949
BUREAU V. S.

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

F 06303

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Green Ridge Addition; LENGTH OF STAY (in this place) 6 mos; HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD I Cumberland Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rt 1 Cumberland; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) Woodrow (Last) Baker.

4. DATE OF DEATH: (Month) July (Day) 18 (Year) 1949

5. SEX: F.

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 27 Oct 1880

9. AGE last birthday: 68 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public Schools

11. BIRTHPLACE (State or foreign country): Hartsmanville – W Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Milton Baker

14. MOTHER'S MAIDEN NAME: Rebecca P. Wilt.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinomatosis Generalized.

170 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma Right Breast (Primary)

50 (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1948, to July, 1949, that I last saw the deceased alive on 17 July, 1949, and that death occurred at 1.45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Fuller B. Blackwood MD ADDRESS Cumberland Md DATE SIGNED 18 July 1949.

23. BURIAL, CREMATION REMOVAL (Specify) Burial; DATE THEREOF July 21, 1949; NAME OF CEMETERY OR CREMATORY Baker Family Cemetery; LOCATION (City, town, or county) (State) Laurel Dale W. Va.

DATE REC'D BY LOCAL REG. July 21, 1949; REGISTRAR'S SIGNATURE Hunter R. Trout, M.D.

24. FUNERAL DIRECTOR Rogers Funeral Home ADDRESS Keyser W.Va.

VS. A15

RECEIVED
JUL 26 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06304

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 36 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 124 South St.

3. NAME OF DECEASED (Type or Print): (First) Samuel (Middle) E (Last) Barnes

4. DATE OF DEATH: (Month) July (Day) 2 (Year) 1949

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: Feb. 8-1867

9. AGE last birthday: 82 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repair Heater (retired)

10b. KIND OF BUSINESS OR INDUSTRY: Tin Plate Mill

11. BIRTHPLACE (State or foreign country): Bradford Co. Pa.

12. CITIZEN OF WHAT COUNTRY? U.S/A

13. FATHER'S NAME: Joseph Barnes

14. MOTHER'S MAIDEN NAME: Amy Northcraft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: --------

17. INFORMANT: Mrs. Earnest Pillon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 Immediate cause (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: several years

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) also had hypertention & arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. H.V. Deming M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: July 3-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: July 5, 1949 — NAME OF CEMETERY OR CREMATORY: Mt. Hermon — LOCATION (City, town, or county) (State): Near Cumberland, Md

DATE REC'D BY LOCAL REG.: July 5, 1949 — REGISTRAR'S SIGNATURE: Walter R. Beatty, M.D.

24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland, Md.

RECEIVED
JUL 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH Bc 06305

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: near Cumberland
LENGTH OF STAY (In this place): Fairgo — 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Fairgo

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 131 South Poppleton St.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Leo (Last) Beatty

4. DATE OF DEATH: (Month) July (Day) 20 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: June--1892

9. AGE last birthday: 57 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Putting shoes on horses

10b. KIND OF BUSINESS OR INDUSTRY: Blacksmith

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Beatty

14. MOTHER'S MAIDEN NAME: Mary Mc Call

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-12-4958

17. INFORMANT: brother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

420.1 / 940

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D.	H.V. Deming M.D.	Cumberland Md.	July 21-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-23-1949	New Cathedral Cem	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-21-49	Dexter R. Frantz M.D.	John J. Cowan	Baltimore, Md

RECEIVED
JUL 25 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06366

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

MARGIN RESERVED FOR BINDING

I

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 10 Millman Place

3. NAME OF DECEASED (Type or Print): (First) William (Middle) H. (Last) Bell

4. DATE OF DEATH: (Month) 7 (Day) 5 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: Jan. 21, 1864

9. AGE last birthday: 85 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Miner

11. BIRTHPLACE (State or foreign country): Preston Co., W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Nimrod Bell

14. MOTHER'S MAIDEN NAME: Sarah Anne Currence

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Son - Oliver N. Bell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremic Poisoning	4 Two
442 Antecedent cause(s) 1310 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardiovascular renal Disease	3 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 29, 1949, to July 5, 1949, that I last saw the deceased alive on July 3, 1949, and that death occurred at 5:58 a m. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M.D. 110 S. Centre St. July 5, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: July 7, 1949
NAME OF CEMETERY OR CREMATORY: Philos Cemetery
LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG.: July 7, 1949
REGISTRAR'S SIGNATURE: Winston L. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George
ADDRESS: Cumberland, Md.

RECEIVED
JUL 12 1949
BUREAU V. S.

Within corporate limits: DR WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

P6307

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: MT. LAKE PARK
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Roger BABY (Middle) Carlton BOY (Last) BITTINGER

4. DATE OF DEATH: (Month) JULY (Day) 1 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: JUNE 29, 1949

9. AGE last birthday: yrs. — If under 1 year: Months — Days 2 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND Cumberland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: CARLTON W. BITTINGER

14. MOTHER'S MAIDEN NAME: DOROTHY V. SCHMIDT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage

760.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

160a (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-29, 1949, to 7-1, 1949, that I last saw the deceased alive on 7-1-49, 1949, and that death occurred at 3 44/a.m., from the causes and on the date stated above.

SIGNATURE: Fuller B Whitworth (Degree or title) — ADDRESS: 112 Bedford St. — DATE SIGNED: 7-1-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: July 3, 1949 — NAME OF CEMETERY OR CREMATORY: Accident Cemetery — LOCATION (City, town, or county) (State): Accident, Md.

DATE REC'D BY LOCAL REG.: July 1, 1949 — REGISTRAR'S SIGNATURE: Walter R. Lantz M.D. — 24. FUNERAL DIRECTOR: Herbert C. Leighton — ADDRESS: Oakland Md.

RECEIVED
JUL 6 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06308

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 22 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): ~~Furnace~~ St. 948 Maryland Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Bertrand	Conway	Black	7	18	49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	Divorced	Sept. 1900	58 48 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist helper	Railroad	Cumberland, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William H. Black	Daisy Talbot

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	William H. Black

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Vascular Accident	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Arteriosclerosis	10 yrs
334 / 83a	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec, 1946, to July 18, 1949, that I last saw the deceased alive on July 16, 1949, and that death occurred at 7:00 p.m. from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Gould	M.D.	110 S. Centre St.	7-21-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	July 22, 1949	Sts. Peter & Paul's Cemetery	Cumberland,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 22 1949	Hunter R. Bantz, M.D.	John J. Hofer, Cumberland,	Md.

RECEIVED
JUL 26 1949
BUREAU V. S.

Within corporate limits

Evidence for change of age is shown on

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 121 AUG -8 1949

CERTIFICATE OF DEATH

06309

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 220 Washington St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 220 Washington St.

3. NAME OF DECEASED (Type or Print) (First) Sue (Middle) McEvoy (Last) Brett

4. DATE OF DEATH (Month) July (Day) 29, (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH [redacted] 1901

9. AGE last birthday 47 48 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY U.S.

13. FATHER'S NAME Charles Henry McEvoy

14. MOTHER'S MAIDEN NAME Mary Esther Shearer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Miss. Pauline McEvoy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

291 Immediate cause (a) Cerebral Embolism

92d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Secondary Anemia Blood Dyscrasia 23 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Severe Hemorrhage 23 yrs ago

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 28, 1949, to July 29, 1949, that I last saw the deceased alive on July 28, 1949, and that death occurred at 8 a m., from the causes and on the date stated above.

SIGNATURE E. L. Owens (Degree or title) M.D. ADDRESS Cumberland Md DATE SIGNED July 30-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 8-1-1949

NAME OF CEMETERY OR CREMATORY St. Michaels

LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REG. July 31, 1949

REGISTRAR'S SIGNATURE Winter R. Krantz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

VS. A15

RECEIVED
AUG 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06310

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg Md
LENGTH OF STAY (in this place) 3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Hilton COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED (Type or Print) (First) Lavina (Middle) Brown (Last)

4. DATE OF DEATH (Month) July (Day) 4 (Year) 1949

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 6-1865
9. AGE last birthday 84 yrs. If under 1 year Months 1 Days 29 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Hilton, Garrett Co
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel Garlitz
14. MOTHER'S MAIDEN NAME Isabel Minkey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT George Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hearts failure	6 mo
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterial Sclerosis	20 yrs
	(c)	

450.0
97

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1949, to July 4, 1949, that I last saw the deceased alive on July 4, 1949, and that death occurred at 4 45 p.m., from the causes and on the date stated above.

SIGNATURE Adolf Wolfermann (Degree or title) M.D. ADDRESS Frostburg Md DATE SIGNED 7-6-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 7-1949
NAME OF CEMETERY OR CREMATORY St. Frances Cem.
LOCATION (City, town, or county) (State) Hilton, Garrett Co, Md

DATE REC'D BY LOCAL REG. 7/6/49
REGISTRAR'S SIGNATURE Mrs. Blanche O. Price acting
24. FUNERAL DIRECTOR Wm Whitebeck Grantsville Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 8 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

6311

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
MARYLAND — LENGTH OF STAY (In this place): 80 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gilpintown (rural)
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Commodore		Bucy	July	5	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	widower	Dec. 26-1864	84 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Gilpintown, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Bucy
14. MOTHER'S MAIDEN NAME: [redacted] Anna Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: Frank Bucy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Mesenteric thrombosis	about 2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Perforation of the bowel with obstruction.	
	(c)	

578
1221

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H. V. Deming M.D.	Cumberland Md.	July 5-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7/8/49	Bucy Cemetery	On Town Creek Allegany Co

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 7, 1949	Wenter R. Wantz, M.D.	Charles L. George	Cumberland, Md.

RECEIVED
JUL 12 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

C6312

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 400 Grand Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 400 Grand Ave

3. NAME OF DECEASED (Type or Print): (First) Michiel (Middle) J. (Last) Burns

4. DATE OF DEATH: (Month) July (Day) I6, (Year) I949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 8/23/I864

9. AGE last birthday: 84 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Mech.

10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R.

11. BIRTHPLACE (State or foreign country): Grafton W.Va.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hugh H. Burns

14. MOTHER'S MAIDEN NAME: Anna Hanley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hugh Burns 40I Race St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	3 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	5 yrs
	(c)	

422.1 93d

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 26, 19 49, to July 16, 19 49, that I last saw the deceased alive on July 16, 19 49, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Chas Lewis M.D. Cumberland 7/18/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 7/I9/49

NAME OF CEMETERY OR CREMATORY: St Peters Cem.

LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG.: July 19, 1949

REGISTRAR'S SIGNATURE: Hunter A Brady M.D.

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli I08 Va. Ave.

RECEIVED
JUL 26 1949
BUREAU V. S.

Within corporate limits

Evidence for change of birth date shown on:

FILM No. G 122 OCT 4 1949

06313

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 48 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 349 Davidson Street

3. NAME OF DECEASED (Type or Print) (First) Ida (Middle) Eileen (Last) Butts
4. DATE OF DEATH (Month) July (Day) 26 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH July 10, 1877
9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY House
11. BIRTHPLACE (State or foreign country) Hot Springs, Virginia
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Christopher Harouff
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Sylvester H. Butts

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

170 Immediate cause (a) Pulmonary Embolus — 4 hours

50 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Gallstone Sclerosis — Unknown

(c) Carcinoma, Breast — Unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Intestinal Obstruction — Unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 23, 1949, to July 26, 1949, that I last saw the deceased alive on July 26, 1949, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS 404 Decatur St Cumberland DATE SIGNED 4/28/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 28 1949
NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park
LOCATION (City, town, or county) Cumberland, (State) Maryland

DATE REC'D BY LOCAL REG. July 28, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR William H. Kight, ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 2 1949
BUREAU V. S.

Within corporate limits

Dr. Truett

MARYLAND STATE DEPARTMENT OF HEALTH

06314

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

MARGIN RESERVED FOR BINDING

I

T

VS. A15

1. PLACE OF DEATH COUNTY: Allegany — MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland LENGTH OF STAY (In this place): 40 Yrs HOSPITAL OR INSTITUTION OR STREET ADDRESS: 130 Grand Ave.	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland — COUNTY: Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland STREET ADDRESS (If rural, give location): 130 Grand Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John William	Chesnut		July	24,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	2-10-1870	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Paper Hanger	Hustontown, Penna.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Chesnut	Elizabeth Lyon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.	None	Mrs. Alice V. Hauger

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
462.1 Immediate cause	(a) Coronary Thrombosis	Sudden
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Esophageal Varicis	4 yrs.
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June, 1946, to July 24, 1949, that I last saw the deceased alive on July 23, 1949, and that death occurred at 1 9. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Clary E. Lumitt	M. D.	Cumberland	7/25/49.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-27-1949	Rose Hill	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 27, 1949	Walter K. Frantz, M.D.	Charles L. George	Cumberland, Md.

RECEIVED
AUG 2 1949
BUREAU V. S.

06315

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Alleghany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Alleghany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Serafina (Middle) (Last) Cicchetto			4. DATE OF DEATH (Month) July (Day) 30 (Year) 1949		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 29, 1888	9. AGE last birthday 61 yrs.	If under 1 year Months 3 Days 1 — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Solomon, Italy	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francisco Poilucci			14. MOTHER'S MAIDEN NAME Anna Desandos		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.		17. INFORMANT Michele Cicchetto		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Congestive Heart Failure	5 days
260 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	3 yrs
61	(c) Diabetes Mellitus	3 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1947, to July 30, 1949, that I last saw the deceased alive on July 30, 1949 and that death occurred at 10:00 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Harry Sloppman M.D. ADDRESS Keyser, W.Va. DATE SIGNED 8-1-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 8-2-49	NAME OF CEMETERY OR CREMATORY St. Thomas	LOCATION (City, town, or county) (State) Keyser, W.Va.
DATE REC'D BY LOCAL REG. Aug 2/49	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Rogers Funeral Home	ADDRESS Keyser, W.Va.

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1949
BUREAU T. S.

06316

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Frank (Middle) (Last) Condry

4. DATE OF DEATH (Month) July (Day) 8 (Year) 1949

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH July 9 1892

9. AGE last birthday 57 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY Miner

11. BIRTHPLACE (State or foreign country) Elk Garden W Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Condry

14. MOTHER'S MAIDEN NAME Mollie Hershberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) es (If yes, give war or dates of service) World I

16. SOCIAL SECURITY NO.

17. INFORMANT Mary Rafferty

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chr Myocarditis	6 mo
334 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	3 yrs
93d	(c) Left Hemiplegia	2 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945, 19..., to July 8, 1949, that I last saw the deceased alive on July 5, 1949, and that death occurred at 3:30 A m., from the causes and on the date stated above.

SIGNATURE Wm Lane (Degree or title) MD ADDRESS Frostburg Md DATE SIGNED 7-9-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 7/12/49

NAME OF CEMETERY OR CREMATORY St. Michael

LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. 7-11-49

REGISTRAR'S SIGNATURE Mrs. Blanche O. Price Acting g.

24. FUNERAL DIRECTOR Harvey H. Leigler ADDRESS Hyndman, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06317

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 15 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 32 S. Water St.

3. NAME OF DECEASED (Type or Print): (First) ELLEN (Middle) (Last) CORDIAL

4. DATE OF DEATH: (Month) July (Day) 29 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 9-29-1868

9. AGE last birthday: 80 yrs. If under 1 year: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Eckhart, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Cordial

14. MOTHER'S MAIDEN NAME: Katherine Kirby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs. Frank Wolfhope, Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Myocardial Insufficiency — Interval Between Onset and Death: 2 minutes

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Passive Congestion - Cardiac Failure — 1 week

(c) Arteriosclerosis generalized — years

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Cardio vascular renal disease — years

442

933

19a. DATE OF OPERATION: NONE

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NONE

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/28, 1949, to 7/29, 1949 that I last saw the deceased alive on 7/29, 1949 and that death occurred at 1:00 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Maurice Goldstein M.D. ADDRESS: 48 Broadway, Frostburg DATE SIGNED: 8-1-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Aug. 1 1949 — NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 8-1-49 — REGISTRAR'S SIGNATURE: Mrs. Nancy A. Roe

24. FUNERAL DIRECTOR: J. R. Durst, ADDRESS: Frostburg, Md.

RECEIVED
AUG. 3 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06318

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 65 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 346 Central Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland ~~Allegany~~ COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 346 Central Ave

3. NAME OF DECEASED (Type or Print) (First) ELIZABETH (Middle) E (Last) CRABTREE

4. DATE OF DEATH (Month) July (Day) 24 (Year) 1949

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 25, 1883
9. AGE last birthday: 65 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Corrigansville, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Abraham ~~John~~ PRINTY
14. MOTHER'S MAIDEN NAME: Mary Edith Williamson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Chas. Crabtree

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) Myocarditis — 8 mos.

93e Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from March 15, 1949, to July 24, 1949, that I last saw the deceased alive on July 23, 1949, and that death occurred at 2:05 a.m., from the causes and on the date stated above.

SIGNATURE: R. W. Ballin, (Degree or title) M.D. ADDRESS: 62 Greene St. Cumberland Md DATE SIGNED: 7-24-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: July 26, 1949
NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
LOCATION (City, town, or county) (State): Cumberland, Md
DATE REC'D BY LOCAL REG.: July 26, 1949
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: John J. Hafer ADDRESS: Cumberland, Md.

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 2 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06319

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 939 Maryland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 939 Maryland Ave.

3. NAME OF DECEASED (Type or Print) (First) Annie (Middle) G. (Last) Crosby

4. DATE OF DEATH (Month) July (Day) 25, (Year) 1949

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH June 10, 1880

9. AGE last birthday 69 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.

12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME Jonas Crosby

14. MOTHER'S MAIDEN NAME Mary Newman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Joseph Crosby Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331

Immediate cause (a) Uraemia — Interval between onset and death: 4 wks.

83a

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Right Cerebral Hemorrhage — 5 days

(c) Left Hemiplegia — 5 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION July 6, 1949

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1949 to July 25, 1949, that I last saw the deceased alive on July 25, 1949, and that death occurred at 7:45 P m., from the causes and on the date stated above.

SIGNATURE Chas R. Jones (Degree or title) M. D. ADDRESS Cumberland DATE SIGNED 7/26/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF July 28 1949

NAME OF CEMETERY OR CREMATORY St: Patrick Cem

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. July 27, 1949

REGISTRAR'S SIGNATURE Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 2 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06320

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage. LENGTH OF STAY (in this place) 54 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Savage Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location) Mt. Savage Road

3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) Margaret (Last) Crump

4. DATE OF DEATH (Month) July (Day) 4 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Nov 26-1858
9. AGE last birthday 90 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Nancy Brooks
14. MOTHER'S MAIDEN NAME Elizabeth Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT James E. Crump Son.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH 10 mo.

443 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Heart disease

93d (c) Generalized arteriosclerosis. advanced age

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 6, 1949, to July 4, 1949, that I last saw the deceased alive on June 30, 1949, and that death occurred at 10.15 A.M., from the causes and on the date stated above.

SIGNATURE James P. Hallinan (Degree or title) MD, ADDRESS 300 Decatur St Cumberland Md DATE SIGNED July 7 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 7-1949
NAME OF CEMETERY OR CREMATORY St. George's Cem.
LOCATION (City, town, or county) Mt. Savage (State) Md.

DATE REC'D BY LOCAL REG. 7-7-49
REGISTRAR'S SIGNATURE Vernice McDermott
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS

RECEIVED
JUL 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06321

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

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VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 115 Ormand St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 115 Ormand St.

3. NAME OF DECEASED (Type or Print): (First) EDWARD (Middle) (Last) DAVIS

4. DATE OF DEATH: (Month) July (Day) 6, (Year) 19 49

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 2-13-1874

9. AGE last birthday: 75 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery store clerk and owner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ebenezar Davis

14. MOTHER'S MAIDEN NAME: Margaret Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Sarah J. Davis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151

Immediate cause (a) Carcinoma of stomach — Interval between onset and death: 6 Mos.

460

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Secondary Anemia. —

19a. DATE OF OPERATION: none. — 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1949, to July 6, 1949, that I last saw the deceased alive on 7-6, 1949, and that death occurred at 9 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. C. Diehl M.D. Frostburg, Md. (7-8-49)

23. BURIAL, CREMATION / REMOVAL (Specify): burial — DATE THEREOF: 7-9-1949 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 7-9-49 — REGISTRAR'S SIGNATURE: Blanche A. Price Acting

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

RECEIVED
JUL 12 1949
BUREAU V. S.

See Rights Funeral Home

Within corporate limits DR. COOPER

06322

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. LENGTH OF STAY (In this place) 50 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY Morgan
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PAW PAW
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) SALLY (Middle) (Last) DAY

4. DATE OF DEATH (Month) JULY (Day) 18 (Year) 1949

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED

8. DATE OF BIRTH About 1867

9. AGE last birthday 82 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME RANDOLPH LARGENT

14. MOTHER'S MAIDEN NAME SARAH KERNS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

904.0 Immediate cause (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH 4 wks.

186a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pneumonia

(c) Fractured hip

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT ✓ SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home (CITY OR TOWN) Paw Paw (COUNTY) (STATE) W. Va.

TIME OF INJURY (Month) (Day) (Year) (Hour) May 29 1949 ? m. INJURY OCCURRED While at Work ☐ Not While At work ☑ HOW DID INJURY OCCUR? Pt. fell fractured hip

22. I hereby certify that I attended the deceased from 29 May, 1949, to 18 July, 1949, that I last saw the deceased alive on 18 July, 1949, and that death occurred at 9 50 a.m., from the causes and on the date stated above.

SIGNATURE L. S. Cooper (Degree or title) M.D. ADDRESS 101 S. Centre St. DATE SIGNED 18 July 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 7/21/49 NAME OF CEMETERY OR CREMATORY Woodrow Cem. LOCATION (City, town, or county) Paw Paw, W va (State)

DATE REC'D BY LOCAL REG. July 20, 1949 REGISTRAR'S SIGNATURE Hunter R. Frantz, M.D.

24. FUNERAL DIRECTOR W. D. Parks, Berkley Springs, W va ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 26 1949
BUREAU V. S.

Within corporate limits

W.F.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06323

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. | LENGTH OF STAY (in this place) 49 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE PENNSYLVANIA — COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BEDFORD
STREET ADDRESS (If rural, give location) R.F.D.#1. ✓

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) (Last) DIBERT

4. DATE OF DEATH: (Month) JULY (Day) 19 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: OCT. ? 1895

9. AGE last birthday: 53 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ADAM DIBERT

14. MOTHER'S MAIDEN NAME: SARAH BEEGLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Impression of cause of death.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) 1. Carcinoma of Rectum
(c) 2. Hodgkins. (Abdominal type).

201
46e

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Autopsy refused. Would not permit - even a Mid-line incision

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-31-, 1949, to 7-19-, 1949, that I last saw the deceased alive on 7-18-, 1949, and that death occurred at 2:45 p.m., from the causes and on the date stated above.

SIGNATURE W.F. Williams (Degree or title) ADDRESS MD DATE SIGNED 7-30-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 7-21-1949 | NAME OF CEMETERY OR CREMATORY: St. James Luthern | LOCATION (City, town, or county) (State): Bedford, Pa.

DATE REC'D BY LOCAL REG. July 21, 1949 | REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: S. Alton Barefoot ADDRESS: Bedford, Penna.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06324

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9 N. Grant St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 9 N. Grant St.

3. NAME OF DECEASED (Type or Print): (First) MAY (Middle) CARSON (Last) DILLON

4. DATE OF DEATH: (Month) July (Day) 22 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 5-4-1882

9. AGE last birthday: 67 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BENJAMIN CARSON

14. MOTHER'S MAIDEN NAME: JANE LYONS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Nancy Dillon, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chr Myocarditis	6 mos
260 Antecedent cause(s)	(b) Arteio Sclerosis	? ?
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Diabetes	many yeles

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1944, 19..., to July 22, 1949, that I last saw the deceased alive on July 22, 1949, and that death occurred at 5-00 p.m., from the causes and on the date stated above.

SIGNATURE: W. O. McLane M.D. — (Degree or title) — ADDRESS: Frostburg Md — DATE SIGNED: July 23 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 7-25-49 — NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 7-25-49 — REGISTRAR'S SIGNATURE: Mrs Nancy R. Roe

24. FUNERAL DIRECTOR: J. R. Durst, — ADDRESS: Frostburg, Md.

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JUL 28 1949
U. S. P. O.

06325

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Front, St. 308 B.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) Front - 308 B.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Infant Dixon

4. DATE OF DEATH (Month) (Day) (Year) July 25 1949

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH July 25-49
9. AGE last birthday — yrs. If under 1 year Months. Days If under 24 hrs. Hours Min. 1/2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No
10b. KIND OF BUSINESS OR INDUSTRY No
11. BIRTHPLACE (State or foreign country) Westernport, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Floyd Dixon
14. MOTHER'S MAIDEN NAME Madeline Barb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Floyd Dixon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Premature — INTERVAL BETWEEN ONSET AND DEATH Lived 1/2 hr.

776 Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 25, 1949, to July 25, 1949, that I last saw the deceased alive on July 25, 1949, and that death occurred at 6 a. m., from the causes and on the date stated above.

SIGNATURE P. E. Berry (Degree or title) M.D. ADDRESS Piedmont DATE SIGNED W. Va 7/25/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE July 25-49
NAME OF CEMETERY OR CREMATORY Philos Cemetery
LOCATION (City, town, or county) (State) Westernport Md

DATE REC'D BY LOCAL REG. July 25/49
REGISTRAR'S SIGNATURE [illegible] M.D.
24. FUNERAL DIRECTOR Ellsworth S. Boal ADDRESS Westernport, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 29 1940
BUREAU OF

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06326

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (In this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Cumberland, Md.~~ Frostburg
STREET ADDRESS (If rural, give location) [redacted] St., No home

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Humphrey (Last) Evans

4. DATE OF DEATH: (Month) 7 (Day) 7 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan 21, 1879

9. AGE last birthday: 70 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Humphrey Evans

14. MOTHER'S MAIDEN NAME: Ruth Farrady

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	1 wks
422.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	2 years
93d	(c) Senility	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1946, to July 7, 1949, that I last saw the deceased alive on July 6, 1949, and that death occurred at 10:15 a.m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED

Arthur F. Jones M.D. | 110 S. Centre St. | July 7, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 7-9-49 | NAME OF CEMETERY OR CREMATORY: Allegany Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: July 8, 1949 | REGISTRAR'S SIGNATURE: Wesley R. Lantz, M.D. | 25. FUNERAL DIRECTOR | ADDRESS: Jacob Hafer, Cumberland, Md.

RECEIVED
JUL 12 1949
BUREAU V. S.

Within corporate limits MIRKIN

06327

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY Allegany ~~COUNTY~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. LENGTH OF STAY (in this place) 1 HOUR	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.	STREET ADDRESS (If rural, give location) 79 PATTERSON AVE.,

3. NAME OF DECEASED (Type or Print)	(First) CLARA	(Middle) E.	(Last) FAIR	4. DATE OF DEATH	(Month) July (Day) 16 (Year) 1949
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC. 19, 1883	9. AGE last birthday 65 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Louisville Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Defibaugh ~~DEFFINBAUGH~~			14. MOTHER'S MAIDEN NAME LYNCH		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Exsanguination due to bleeding duodenal ulcer -	3-4 mo.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic duodenal ulcer c̄ stenosis	6-7 yrs.
	(c) Chr. rheumatic ht. disease inactive	many yrs

5410
117b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1946, to July 16, 1949, that I last saw the deceased alive on July 16, 1949, and that death occurred at 10 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A J Mirkin	Md	115 S. Centre St.	7/17/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 19, 1949	St. Joseph's	Midland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 22, 1949	Winter R Trantz, M D	Charles L. George	Cumberland, Md,

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 26 1949
BUREAU Y. S.

Within corporate limits

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06328

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) (Last) FANNON
4. DATE OF DEATH (Month) July (Day) 25, (Year) 1949
5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH 5-2-1890
9. AGE last birthday 59 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward Fannon
14. MOTHER'S MAIDEN NAME Ellen Cunningham
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. none
17. INFORMANT AND ADDRESS Lawrence Fannon, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Diabetic Coma	3 days
260 Antecedent cause(s)		
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes	3 years
	(c) Pernicious Anaemia	2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1948, to July 25, 1949 that I last saw the deceased alive on July 25, 1949 and that death occurred at 5:10 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) F. Alan G. Murray Jr. ADDRESS Cumberland Md DATE SIGNED July 25 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 7-28-49
NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery
LOCATION (City, town, or county) Mt. Savage, (State) Md.
DATE REC'D BY LOCAL REG. July 28, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR J. R. Durst, ADDRESS Frostburg, Md.

RECEIVED
AUG 2 1949
BUREAU V. S.

Within corporate limits

DR. TOLSON

06329

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (In this place) 10 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TERRA ALTA,
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print)	(First) NAOMI	(Middle) R.	(Last) FEATHER	4. DATE OF DEATH	(Month) JULY	(Day) 1	(Year) 1949
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 13, 1905	9. AGE last birthday 44 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME WILBUR SECRIST	14. MOTHER'S MAIDEN NAME RACHEL HANLIN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary embolism	40 minutes
602 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Renal calculus - left.	
134a	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 6-22-49	19b. MAJOR FINDINGS OF OPERATION calculus, 3 cm removed	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-20-, 1949 to 7-1-, 1949 that I last saw the deceased alive on 6-30-, 1949, and that death occurred at 4:10 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Howard D. Tolson, M.D.		Cumberland Md.	7-1-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 3, 1949	Ideman Cemetery	Scheer, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 3, 1949	Winter R. Frantz, M.D.	R. Allaison	Terra Alta W.Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 12 1949
BUREAU V. S.

Within corporate DR. VAN ORMER

06330

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 7 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DEER PARK
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) GEORGE (Middle) P. (Last) FITZWATER

4. DATE OF DEATH (Month) JULY (Day) 27 (Year) 1949

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH NOV. 1, 1875
9. AGE last birthday ~~74~~ 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY FARMING
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JOHN L. FITZWATER
14. MOTHER'S MAIDEN NAME EBZAUGH GEORGE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Pulmonary Emboli with infarction and pneumonia with lower lobes	25 July 44
108	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Emboli left femoral artery with gangrene left leg and amputation	19 July 44
		(c) Generalized arteriosclerosis with thrombi heart	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 26 July 49
19b. MAJOR FINDINGS OF OPERATION Gangrene left leg.
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 July 1949 to 27 July 1949, that I last saw the deceased alive on 27 July, 1949, and that death occurred at 11 p.m., from the causes and on the date stated above.

SIGNATURE W. Alfred Van Ormer (Degree or title) ADDRESS Cumberland, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 30, 1949
NAME OF CEMETERY OR CREMATORY Deer Park
LOCATION (City, town, or county) Deer Park (State) Md

DATE REC'D BY LOCAL REG. July 29, 1949
REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.
24. FUNERAL DIRECTOR Emroy Bolden ADDRESS Oakland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 2 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06331

Reg. Dist. No. 9

M — The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This is especially important. Physicians: please write the causes of death clearly and legibly.

I — T

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg Md; LENGTH OF STAY (In this place) 1 week; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Ohio; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Youngstown; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) Victor (Last) Folk

4. DATE OF DEATH: (Month) 7 (Day) 9 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 6/9/49

9. AGE last birthday: yrs.; If under 1 year: Months 1 mo, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Youngstown, Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Webster Folk Jr.

14. MOTHER'S MAIDEN NAME: Charlotte A. Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Harry W. Folk Jr. (Father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lobar Pneumonia — Interval Between Onset and Death: 1 week

490 / 108 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute Upper Respiratory Infx

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION.

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/6, 1949, to 7/9, 1949, that I last saw the deceased alive on 7/9, 1949, and that death occurred at 12:55 p.m., from the causes and on the date stated above.

SIGNATURE John B. Davis (Degree or title) MD ADDRESS Frostburg, Md DATE SIGNED 7/9/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial; DATE THEREOF 7/10/49; NAME OF CEMETERY OR CREMATORY Blacker Cemetery; LOCATION (City, town, or county) Long Stretch (State) Garrett Co. Md.

DATE REC'D BY LOCAL REG. 7-9-49; REGISTRAR'S SIGNATURE Blanche O. Price Acting; 24. FUNERAL DIRECTOR Jacob Hofer; ADDRESS Frostburg, Md.

RECEIVED
JUL 12 1949
BUREAU OF S.

Within corporate limits 78

06332

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1015 Gay St.,

3. NAME OF DECEASED (Type or Print) (First) MARGARET (Middle) FRANCES (Last) FORBECK

4. DATE OF DEATH (Month) July (Day) 6, (Year) 1949

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Mar. 14, 1895 | 9. AGE last birthday 54 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Little Orleans, Md. | 12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME William F. Robey | 14. MOTHER'S MAIDEN NAME Lucinda Youngblood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Robert A. Forbeck

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pneumonia	4 days
334 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hemiplegia right	
83d	(c) Hypertension	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1949, to July 6, 1949, that I last saw the deceased alive on July 6, 1949, and that death occurred at 12:05 P m., from the causes and on the date stated above.

SIGNATURE George M Simons (Degree or title) M.D. ADDRESS 128 Union St Cumberland Md DATE SIGNED July 8, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 7/9/49 | NAME OF CEMETERY OR CREMATORY Mt. Herman | LOCATION (City, town, or county) (State) Near Cumberland, Md.

DATE REC'D BY LOCAL REG. July 9, 1949 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 12 1949
BUREAU V. R.

Within corporate limits

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06333

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 2 hrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, give location) 37 Oak Street

3. NAME OF DECEASED (Type or Print)	(First) WILLIAM	(Middle) S.	(Last) FOUTCH	4. DATE OF DEATH	(Month) July	(Day) 6,	(Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 4/6/1889	9. AGE last birthday 60 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman - Retired	10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.	11. BIRTHPLACE (State or foreign country) Morgan County, West Virginia	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Louis W. Foutch	14. MOTHER'S MAIDEN NAME Amanda Linaburg						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Kenneth Gray, Cumberland, Md.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute coronary occlusion	2 hours
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arterial hypertension	1 year
94a	(c) —	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 4-3-, 1949, to 7-6, 1949, that I last saw the deceased alive on 7-6-, 1949, and that death occurred at 1 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L Wrings	M D	59 Greene P., Cumberland Md	7-7-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF July 8, 1949	NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	LOCATION (City, town, or county) (State) Near Cumberland, Maryland
DATE REC'D BY LOCAL REG. July 7, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Maryland	ADDRESS

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BUREAU V. S.

Within corporate limits

HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06334

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 11 HRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL Hospital CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND,
STREET ADDRESS (If rural, give location): 436 PINE AVE.,

3. NAME OF DECEASED (Type or Print): (First) Baby (Middle) Girl (Last) GATES

4. DATE OF DEATH: (Month) July (Day) 4 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: COLORED

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): NEWBORN

8. DATE OF BIRTH: July 4, 1949

9. AGE last birthday: yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours 11 Min. 16

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: BRUCE E. GATES

14. MOTHER'S MAIDEN NAME: ROBERTA E. WALKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity (5 1/2 mon.)

761.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Partial placental seperation

160c (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 4, 1949 to July 4, 1949, that I last saw the deceased alive on July 4, 1949 and that death occurred at 1:29 P. m. from the causes and on the date stated above.

SIGNATURE (Degree or title) W Rayse Hodges, M.D. ADDRESS Cumberland, Md. DATE SIGNED 7/5/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
CREMATION	JULY 5, 1949	MEMORIAL HOSPITAL	CUMBERLAND, ALLEG., MD.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 5, 1949	Winter R. Frantz, M.D.	Memorial Hospital,	Cumberland Md.

RECEIVED
JUL 12 1949
BUREAU V. S.

Within corporate limits

DR. MIRKIN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06335

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (In this place) 7 yrs 9 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 216 MARYLAND AVE.

3. NAME OF DECEASED (Type or Print): (First) ROBERT (Middle) (Last) GRIFFITH

4. DATE OF DEATH: (Month) July (Day) 22 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: DEC. 3 1865

9. AGE last birthday: 83 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None Mine owner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mining

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM GRIFFITH

14. MOTHER'S MAIDEN NAME: JENNIE MORRISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Lawrence Griffith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bronchopneumonia	3-4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Gangrene left leg distal to knee due to erosion of popliteal A.	11 days
690.6 / 131 a	(c) due to Carbuncle of popliteal fossa	2 wks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis & Nephrosclerosis — Years

19a. DATE OF OPERATION: 7- -49

19b. MAJOR FINDINGS OF OPERATION: Gangrenous L. leg from knee distally

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Mouth) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to July 22, 1949 that I last saw the deceased alive on July 21 1949, and that death occurred at 2:00 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) A. Mirkin M.D. — ADDRESS 115 S. Centre St. — DATE SIGNED 7/22/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 24, 1949	Allegany Cemetery	Frostburg Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 26, 1949	Walter L. Lantz, M.D.	John J. Hafer	Cumberland, Md.

RECEIVED
AUG 2 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06336

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 126 Bedford St.

3. NAME OF DECEASED (Type or Print): (First) WILLIAM; (Middle) JAMES; (Last) GRIM

4. DATE OF DEATH: (Month) July; (Day) 27; (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 10-28-1910

9. AGE last birthday: 38 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): engineering dept.

10b. KIND OF BUSINESS OR INDUSTRY: Amer. Viscose

11. BIRTHPLACE (State or foreign country): Eckhart, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Grim

14. MOTHER'S MAIDEN NAME: Bessie Bannatyne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service)

16. SOCIAL SECURITY No.: 217-10-4940

17. INFORMANT AND ADDRESS: Mrs. Bernice Grim, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

157 Immediate cause (a) biliary obstruction — Interval Between Onset and Death: 2 months

460 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Cancer of the pancreas — 8 months
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: June 1949

19b. MAJOR FINDINGS OF OPERATION: carcinoma of head of pancreas

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 15, 1949, to July 27, 1949, that I last saw the deceased alive on July 26, 1949, and that death occurred at 5:15 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Adolf Wolferman M.D. — ADDRESS: Frostburg, Md. — DATE SIGNED: 7-28-49

23. BURIAL, CREMATION / REMOVAL (Specify): Burial — DATE: July 29 '49 — NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery — LOCATION (City, town, or county) (State): Eckhart, Md.

DATE REC'D BY LOCAL REG.: 7-29-49 — REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe

24. FUNERAL DIRECTOR: J. R. Durst, — ADDRESS: Frostburg, Md.

RECEIVED
AUG 3 1949
BUREAU V, S.

Dr. W. Lane

06337

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. It is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): all his life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 144 Bowery St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JAMES	HENRY	GROSE	July	6,	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	widowed	5-16-1868	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Maryland	USA

13. FATHER'S NAME: James Grose
14. MOTHER'S MAIDEN NAME: Jane Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
No		Everett Grose

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chr Myocarditis	6 mo
422.1 932 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerosis	several years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
nil				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan 3, 1949, to July 6, 1949, that I last saw the deceased alive on July 5, 1949 and that death occurred at 5:30 A m. from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W M Lane	MD	Frostburg Md	July 6 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-8-49	Allegany Cemetery	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-7-49	Mrs. Blanche O. Price Acting	J. R. Durst,	Frostburg, Md.

9.

RECEIVED
JUL 8 1949
BUREAU V. S.

Within corporate limits

Dr. Trevaskis

06338

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 67 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 134 Arch St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 134 Arch Street
STREET ADDRESS (If rural, give location) Cumberland,

3. NAME OF DECEASED (Type or Print) (First) George (Middle) William (Last) Gross
4. DATE OF DEATH (Month) July (Day) 10 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 3, 1882
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilermaker
10b. KIND OF BUSINESS OR INDUSTRY B+O R R
11. BIRTHPLACE (State or foreign country) Orleans Cross Roads, W Va
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James A. Gross
14. MOTHER'S MAIDEN NAME Mary A. Goldizen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 705-14-0554
17. INFORMANT Mrs George W. Gross

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Idiopathic Thrombopenic Purpura	14 Mos
	(c)	

296
83a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1949, to July 10, 1949, that I last saw the deceased alive on July 10, 1949, and that death occurred at 5 P. m., from the causes and on the date stated above.

SIGNATURE R. W. Trevaskis Sr. (Degree or title) M. D. ADDRESS Cumberland, Md DATE SIGNED July 12-'49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 13 1949
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) (State) Cumberland, Md

DATE REC'D BY LOCAL REG. July 13, 1949
REGISTRAR'S SIGNATURE Wintes R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland, Md.

I

T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 15 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06339

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; LENGTH OF STAY (In this place) 19 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS East Main Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural give location) East Main Street

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Schafer (Last) Hamilton

4. DATE OF DEATH: (Month) July (Day) 26 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 7 1870

9. AGE last birthday: 79 yrs. If under 1 year (Months) If under 1 year (Days) If under 24 hrs. (Hours) If under 24 hrs. (Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: In own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Henry Schafer

14. MOTHER'S MAIDEN NAME: Engelbrandt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Miss Marg. Hamilton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 Immediate cause (a) Cerebral Vascular Accident — Hemorrhage — Interval between onset and death 3 da

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive - Arteriosclerotic Cardio (?)

(c) Vascular disease —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/24, 1949, to 7/26, 1949, that I last saw the deceased alive on 7/26, 1949, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE Paul Eugene Frye (Degree or title) M.D. ADDRESS Lonaconing Md. DATE SIGNED 7/25/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF July 28 '49

NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery

LOCATION (City, town, or county) Lonaconing (State) Md

DATE REC'D BY LOCAL REG. July 28 1949

REGISTRAR'S SIGNATURE Jeanette M Boal

24. FUNERAL DIRECTOR M. E. Eichhorn ADDRESS Lonaconing Md.

RECEIVED
AUG 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06340

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 84 Mechanic

3. NAME OF DECEASED (Type or Print): (First) Gertrude (Middle) Happey (Last)

4. DATE OF DEATH: (Month) July (Day) 3 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: Aug 16 1873

9. AGE last birthday: 75 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Keyser, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: C. E. Ralston

14. MOTHER'S MAIDEN NAME: Laura Ridgeway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs Grace Piper

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uremic Coma	2 Days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fracture neck Rt Femur	5 Days
	(c)	

903.0
186a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma Rt Breast

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident; PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home; (CITY OR TOWN) Frostburg; (COUNTY) Allegany; (STATE) Md

TIME OF INJURY (Month) June (Day) 28 (Year) 49 (Hour) 4 PM; INJURY OCCURRED While at Work ☐ Not While At work ☒; HOW DID INJURY OCCUR? Tripped over chair in home

22. I hereby certify that I attended the deceased from June 28, 1949 to July 3, 1949, that I last saw the deceased alive on July 3, 1949 and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Wm Lane MD; ADDRESS: Frostburg Md; DATE SIGNED: July 4 1949

23. BURIAL, CREMATION / REMOVAL (Specify): Burial; DATE THEREOF: 7-9-49; NAME OF CEMETERY OR CREMATORY: Oldtown; LOCATION (City, town, or county) (State): Oldtown - Alleg. Md.

DATE REC'D BY LOCAL REG. 7-7-49; REGISTRAR'S SIGNATURE: Mrs. Blanche O. Price Acting

24. FUNERAL DIRECTOR: Joseph R. Hurst; ADDRESS: Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 8 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06341

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (in this place): 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 216 Carroll St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 216 Carroll St

3. NAME OF DECEASED (Type or Print): (First) Phyllis (Middle) Louise (Last) Hays
4. DATE OF DEATH: (Month) July (Day) 31 (Year) 19 49

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow
8. DATE OF BIRTH: Dec. 25-1854
9. AGE last birthday: 94 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house work
10b. KIND OF BUSINESS OR INDUSTRY: household duties
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Charles Christian
14. MOTHER'S MAIDEN NAME: Millie Strange

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: --
17. INFORMANT: Mrs. John E. Trimble

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (420.1)	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (94a)	(b) Coronary sclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Paraplegia — 3 years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. July 31-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: August 3, 1949 | NAME OF CEMETERY OR CREMATORY: Woodlawn Cem. | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Aug. 3, 1949 | REGISTRAR'S SIGNATURE: W.K. Lantz M.D. | 24. FUNERAL DIRECTOR: John J. Hafer | ADDRESS: Cumberland, Md.

RECEIVED
AUG 4 1949
BUREAU V. S.

DR. W.F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06342

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: ALLEGANY	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: West Virginia COUNTY: Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland	LENGTH OF STAY (In this place): 19 days
	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Petersburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): [redacted] ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
DORA	A.	HAWSE	JULY 24, 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
FEMALE	WHITE	MARRIED	MAY 4, 1895	54 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Hardy County, W. Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ELI BUNKHOUSER	CARRIE BOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.	None	C. E. Hawse, Petersburg, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Subarachnoid Hemorrhage	7-13-49.
330 Antecedent cause(s) 83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterial Sclerosis Diffuse, marked	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7-13-, 1949, to 7-24-, 1949, that I last saw the deceased alive on 7-24-, 1949, and that death occurred at 8:05 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W.F. Williams	M.D.	Cumberland	7-24-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 27, 1949	Asbury Cemetery	Fairmont, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 24, 1949	Walter K. Frantz, M.D.	P.E. Hawse & Son	Petersburg W. Va.

VS. A15

RECEIVED
AUG 2 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06343

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 317 Broadway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 317 Broadway

3. NAME OF DECEASED (Type or Print): (First) ELIZA (Middle) JANE (Last) HUMBERTSON

4. DATE OF DEATH: (Month) July (Day) 25, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 30, 1883

9. AGE last birthday: 65 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Elk Garden, W. Va.

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: James Grady

14. MOTHER'S MAIDEN NAME: Laura Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: William G. Humbertson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260 Immediate cause (a) Cerebro vascular accident — Interval Between Onset and Death: 3 months

61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — 10 yrs

(c) Diabetes — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 15, 1949, to July 25, 1949, that I last saw the deceased alive on July 24, 1949, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) George M Lemmon MD. ADDRESS 128 Union St Cumberland Md DATE SIGNED

23. BURIAL, CREMATION or REMOVAL (Specify): BURIAL — DATE THEREOF: 7/28/49 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. — LOCATION (City, town or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. July 27, 1949 — REGISTRAR'S SIGNATURE Walter K. Lantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

VS. A15

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AUG 2 1949
BUREAU V. S.

06344

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
MARYLAND
LENGTH OF STAY (in this place): 17 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Henry (Last) Jenkins

4. DATE OF DEATH: (Month) July (Day) 5 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: June 20-1949

9. AGE last birthday: 0 yrs. If under 1 year: Months 0 Days 17 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Westernport Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Benjamine B. Jenkins

14. MOTHER'S MAIDEN NAME: Mary Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: B.B. Jenkins

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Prematurely 7 months	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Atelectasis of lungs-bilateral	
	(c)	

7625
159

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title): H.V. Deming M.D. H.V. Deming M.D.

ADDRESS: Cumberland Md.

DATE SIGNED: July 5-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 7/6/49

NAME OF CEMETERY OR CREMATORY: Phillips Cem

LOCATION (City, town, or county) (State): Westernport Md

DATE REC'D BY LOCAL REG.: July 6/49

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: E.L. Boal

ADDRESS: Westernport Md

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JUL 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06345

Reg. Dist. No. 6-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Pinto; LENGTH OF STAY (In this place): 11 months; MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D. Cresaptown

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Pinto; STREET ADDRESS (If rural, give location): R.F.D.Cresaptown

3. NAME OF DECEASED (Type or Print): (First) Jean (Middle) Elizabeth (Last) Keefuaver

4. DATE OF DEATH: (Month) July (Day) 2 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: July 23-1948

9. AGE last birthday: 0 yrs. If under 1 year: Months 11; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Donald L. Keefuaver

14. MOTHER'S MAIDEN NAME: Florence Jean Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): -- (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: -- -

17. INFORMANT: Donald L.Keefuaver

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asphyxia from drowning — about 5 min.

929.0 / 183 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Bathtub over 1/4 full of water, mother put her two children in it towash them, left them (c) for a few minutes, when she returned, the one was lying face down in the water.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: home

(CITY OR TOWN): Rural) Pinto (COUNTY): Allegany (STATE): Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY: July 2/49-6:35 P m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Drown in bathtub.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V.Deming M.D — H.V. Deming M.D — ADDRESS: Cumberland Md. — DATE SIGNED: July 2-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: July 4 1949 — NAME OF CEMETERY OR CREMATORY: Rose Memorial Park — LOCATION (City, town, or county) (State): Near Cumberland, Maryland

DATE REC'D BY LOCAL REG.: July 4, 1949 — REGISTRAR'S SIGNATURE: M. Kennedy

24. FUNERAL DIRECTOR: Chas. L. George — ADDRESS: Cumberland, "

RECEIVED
JUL 20 1949
BUREAU F. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

Within corporate limits

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06346

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Hawaii — COUNTY: Island
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Honolulu
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Peter (Middle) K (Last) Kinolau

4. DATE OF DEATH: (Month) July (Day) 9 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: May 2-1889

9. AGE last birthday: 60 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal Clerk, Money Order Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Honolulu

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Domiovesto Kinolau

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ?

16. SOCIAL SECURITY No.: ?

17. INFORMANT: wife) Ruth L. Kinolau

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary embolism — Interval between onset and death: about 3 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) due to a fracture of the left hip.

816.5
170c

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Route 36 near (CITY OR TOWN) Barrellsville (COUNTY) Allegany (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): July 6/49-2.15 P

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Collision between Auto. & C & W. Bus.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. — H.V. Deming M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: July 9-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: July 13 1949 — NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery — LOCATION (City, town, or county) (State): Portsmouth, Ohio.

DATE REC'D BY LOCAL REG.: July 9, 1949 — REGISTRAR'S SIGNATURE: Winter R. Krantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight, Cumberland, Md.

VS. A15A

RECEIVED
JUL 18 1949
BUREAU P. S.

Within corporate limits

06347

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY: Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) John (Middle) William (Last) Klipstein Jr.
4. DATE OF DEATH (Month) July (Day) 15 (Year) 1949
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: Dec. 2-1946
9. AGE last birthday: 2 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -----
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Wm. Klipstein Sr.
14. MOTHER'S MAIDEN NAME: Ruth L Dye
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ----
16. SOCIAL SECURITY No.: None
17. INFORMANT: Chart at Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Asphyxia due to anesthesia	15 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Acute dilatation of the heart	
	(c)	

560.5
1220

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Memorial H. (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) July 15/49 9:25 A.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Anesthetic for herniotomy

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: H.V.Deming M.D. H.V. Deming M.D. (Degree or title) ADDRESS: Cumberland Md. DATE SIGNED: July 15-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: July 18, 1949
NAME OF CEMETERY OR CREMATORY: Laurel Hill
LOCATION (City, town, or county): Moscow (State) Md.
DATE REC'D BY LOCAL REG.: 7-18-49
REGISTRAR'S SIGNATURE: Winter R Trantz, M.D.
24. FUNERAL DIRECTOR: C. J. Boal
ADDRESS: Westernport Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 25 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06348

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 72 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 226 N. Lee St.

3. NAME OF DECEASED (Type or Print): (First) Godfrey (Middle) C. (Last) Kotschenreuther
4. DATE OF DEATH: (Month) July (Day) 17 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Jan 13 1877
9. AGE last birthday: 72 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk. retired
10b. KIND OF BUSINESS OR INDUSTRY: W. Md Ry.
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Kotschenreuther
14. MOTHER'S MAIDEN NAME: Catherine Seiss
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-10-7896
17. INFORMANT: Leo G. Kotschenreuther

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) congestive heart failure — 6 weeks

420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerotic heart donor — 1 year

93d (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 3, 1948, to June 17, 1949, that I last saw the deceased alive on June 17, 1949, and that death occurred at 8P m., from the causes and on the date stated above.

SIGNATURE: C. Wing (Degree or title) MD — ADDRESS: 5 G Greene St. — DATE SIGNED: 7-18-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: July 20 49 — NAME OF CEMETERY OR CREMATORY: St Peter & Paul's Ann — LOCATION (City, town, or county): Cumberland (State) Md

DATE REC'D BY LOCAL REG.: July 19, 1949 — REGISTRAR'S SIGNATURE: Winter R Frantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland.

49 72 77

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 28 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06349

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH — COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural R.#4 Twiggtown Rd. Cumberland; LENGTH OF STAY (In this place): 73 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D #4 Twiggtown Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Cumberland; STREET ADDRESS (If rural, give location): R.F.D #4 Twiggtown Rd.

3. NAME OF DECEASED (Type or Print): (First) Louis (Middle) E. (Last) Kuhns

4. DATE OF DEATH: July 10 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: April-15-1876

9. AGE last birthday: 73 yrs.

If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Kuhn

14. MOTHER'S MAIDEN NAME: Mary Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT: Mrs. Jessie Kuhn

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
Immediate cause	(a)	Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Coronary sclerosis	?
420.1 942a	(c)	also had arteriosclerosis	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.	Cumberland Md.	July 10-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 12, 1949	St. Luke's Lutheran Cemetery	Cumberland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
July 12, 1949	Barbara M. BENDER	John J. Hofer, Cumberland, Md.

RECEIVED
JUL 16 1949
BUREAU T. S.

Within corporate limits: DR. GRACIE OR DR. DYER

06350

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
LENGTH OF STAY (In this place): 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: WEST VIRGINIA — COUNTY: Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ARTHUR
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) McKINLEY (Middle) (Last) LAYMAN

4. DATE OF DEATH: (Month) JULY (Day) 2 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: About 1899

9. AGE last birthday: 50 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): W Va

12. CITIZEN OF WHAT COUNTRY: U S

13. FATHER'S NAME: Do not know

14. MOTHER'S MAIDEN NAME: Anna Layman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY No.: none

17. INFORMANT: Homer Sherman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Peritonitis	6 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Intestinal obstruction	8 days
	(c)	

570.5
122.8

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: June 24, 1949

19b. MAJOR FINDINGS OF OPERATION: Intestinal obstruction (peritonitis)

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 27, 1949, to July 2, 1949, that I last saw the deceased alive on July 2, 1949, and that death occurred at 12:35 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED: John G. Dyer, M.D. 247 Virginia Ave. 7-2-49

23. BURIAL CREMATION REMOVAL (Specify): Burial — DATE THEREOF: July 3-1949 — NAME OF CEMETERY OR CREMATORY: Rahmansville — LOCATION (City, town, or county): Rahmansville — (State): W Va

DATE REC'D BY LOCAL REG.: July 3, 1949 — REGISTRAR'S SIGNATURE: Winter L. Lantz M.D.

24. FUNERAL DIRECTOR: Earle Bush — ADDRESS: Petersburg W Va

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

RECEIVED
JUL 12 1949
BUREAU V. B.

Within corporate limits

Richard Williams

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06351

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 54 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 609 Quebec Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 609 Quebec Ave.

3. NAME OF DECEASED (Type or Print): (First) Samuel (Middle) Edward (Last) Manning

4. DATE OF DEATH: (Month) July (Day) 18 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 15, 1883

9. AGE last birthday: 65 yrs.

If under 1 year: Months — Days; If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10b. KIND OF BUSINESS OR INDUSTRY: K-S Tire Co.

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James P. Manning

14. MOTHER'S MAIDEN NAME: Meyers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Thelma Manning

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	72 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	3 mos
	(c)	

4222
932

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN): Cumberland (COUNTY): Alleg (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 10, 1949, to July 18, 1949, that I last saw the deceased alive on July 18, 1949, and that death occurred at 7:10 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): O. J. Williams M.D. — ADDRESS: Cumberland Md — DATE SIGNED: 7/21/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: July 21, 1949

NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery

LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: July 21, 1949

REGISTRAR'S SIGNATURE: Hunter R. Crouch, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer, Cumberland, Md.

RECEIVED
JUL 28 1949
BUREAU T. S.

06352

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 2

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Highway Route 40
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS West side of Sidling Mt. near Bear Creek Bridge

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wheeling
STREET ADDRESS (If rural, give location) 4014 Jacob St.

3. NAME OF DECEASED (Type or Print) (First) Eleanor (Middle) E. (Last) McFarland
4. DATE OF DEATH (Month) July (Day) 4 (Year) 1949
5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH June 13-1915
9. AGE last birthday 34 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press operator
10b. KIND OF BUSINESS OR INDUSTRY Mill Wheeling Steel
11. BIRTHPLACE (State or foreign country) Benwood W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Earl McFarland
14. MOTHER'S MAIDEN NAME Grace Kirwood
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 233-03-0372
17. INFORMANT Catherine Booth

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral hemorrhage due to a crushed skull at once

822.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) from an automobile accident.

170c (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. *
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highway
(CITY OR TOWN) West side of Sidling hill Route 40 (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) July 4/49-4.20 P m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Auto. rolled over several times on a curve. Driver lost control.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED July 5-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 7, 1949
NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
LOCATION (City, town, or county) Wheeling (State) W. Va
DATE REC'D BY LOCAL REG. July 5, 1949
REGISTRAR'S SIGNATURE Mrs Harry Bender
24. FUNERAL DIRECTOR James J. Sunfelt ADDRESS Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 9 1949
BUREAU V. S.

06353

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
LENGTH OF STAY (in this place) 38 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Detmold Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) Detmold Street

3. NAME OF DECEASED (Type or Print) (First) Garlitz (Middle) Andrew (Last) McKenzie

4. DATE OF DEATH (Month) July (Day) 19 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov 23, 1910
9. AGE last birthday 38 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy Worker
10b. KIND OF BUSINESS OR INDUSTRY Dairy
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Clarence McKenzie
14. MOTHER'S MAIDEN NAME Sara Dunn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 214-07-0613
17. INFORMANT Clarence W. McKenzie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	10 min
420.1 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) " embolism	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/19, 1949, to 7/19, 1949, that I last saw the deceased alive on 7/19, 1949, and that death occurred at 6 15 A.m., from the causes and on the date stated above.

SIGNATURE Paul Eugene Inge (Degree or title) M.D. ADDRESS Lonaconing Md. DATE SIGNED 7/19/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 21 '49
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. July 21 1949
REGISTRAR'S SIGNATURE Jannette M Doal
24. FUNERAL DIRECTOR M. Eichhorn ADDRESS Lonaconing Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 26 1949
BUREAU T. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

06354

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 25 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 110 Karns Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 110 Karns Ave

3. NAME OF DECEASED (Type or Print) (First) Edwin (Middle) (Last) Mellott

4. DATE OF DEATH (Month) July (Day) 17 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH April 22-1879

9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter

10b. KIND OF BUSINESS OR INDUSTRY Building

11. BIRTHPLACE (State or foreign country) Pa.

12. CITIZEN OF WHAT COUNTRY? U.S/A.

13. FATHER'S NAME George Mellott

14. MOTHER'S MAIDEN NAME Dorothy Wakefield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 414-05-5779

17. INFORMANT Mrs. Edna Mellott

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary tuberculosis	2 yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

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13b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED July 17-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 7-21-49 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) Hancock (State) Md

DATE REC'D BY LOCAL REG. 7-18-49 REGISTRAR'S SIGNATURE Winter R Frantz M.D.

24. FUNERAL DIRECTOR Chas Bast ADDRESS Hancock Md

RECEIVED
JUL 25 1949
BUREAU T. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06355

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
LENGTH OF STAY (in this place) 57 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS St Marys Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location) Water Station Run

3. NAME OF DECEASED (Type or Print) (First) Helen (Middle) Elizabeth (Last) Miller
4. DATE OF DEATH (Month) July (Day) 25, (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Mch 1st 1892
9. AGE last birthday 57 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY St Marys Rec
11. BIRTHPLACE (State or foreign country) Maryland State
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Alonzo Miller
14. MOTHER'S MAIDEN NAME Mary Walsh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT Mrs James Cunningham

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 Immediate cause (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio Vascular

(c) disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1948, to 7/24, 1949, that I last saw the deceased alive on 7/24, 1949, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE Earl Eugene Frey (Degree or title) M.D. ADDRESS Lonaconing Md. DATE SIGNED 7/26/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 27 49
NAME OF CEMETERY OR CREMATORY St. Marys Cemetery
LOCATION (City, town, or county) Lonaconing (State) Md

DATE REC'D BY LOCAL REG. 7/29/49
REGISTRAR'S SIGNATURE Jannette M Bool
24. FUNERAL DIRECTOR M. Elchhorn ADDRESS Lonaconing, Md

RECEIVED
AUG 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

06356

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 10 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg - rural
STREET ADDRESS (If rural, give location) Savage Mt.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Bernard (Last) Minnich

4. DATE OF DEATH: (Month) July (Day) 13 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 4-4-1876

9. AGE last birthday: 73 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rubber worker

10b. KIND OF BUSINESS OR INDUSTRY: Rubber Manufacturing

11. BIRTHPLACE (State or foreign country): Frostburg, Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jacob Minnich

14. MOTHER'S MAIDEN NAME: Anna Rainer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY No.: 214-05-9951

17. INFORMANT AND ADDRESS: Allen Minnich - Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic heart disease — Interval Between Onset and Death: 5-6 years

Antecedent cause(s) (b) Arteriosclerotic hypertensive heart and kidney disease — 5-6 yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

4422
1310

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1949, to July 13, 1949, that I last saw the deceased alive on July 13, 1949, and that death occurred at 11 55 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Hilda Jane Walters MD — ADDRESS: E.S. Frostburg Md — DATE SIGNED: 7/16/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 7-16-49 — NAME OF CEMETERY OR CREMATORY: St Michaels — LOCATION (City, town, or county) (State): Frostburg-alleg-Md.

DATE REC'D BY LOCAL REG. 7-16-49 — REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe

24. FUNERAL DIRECTOR: Joseph R. Durst — ADDRESS

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 18 1949
BUREAU T. S.

Within corporate limits

M

I

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

06357

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) ~~Furnace St.~~ 507 Bedford St.

3. NAME OF DECEASED (Type or Print) (First) Sylvia (Middle) (Last) Mitchell

4. DATE OF DEATH (Month) 7 (Day) 8 (Year) 1949

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH about 1871

9. AGE last birthday 78 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Turkey

12. CITIZEN OF WHAT COUNTRY? Turkey

13. FATHER'S NAME -------Christ Alexoudis

14. MOTHER'S MAIDEN NAME Mary Varvouzanis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs. Often -(Christ at Eatwell Gr.)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Cerebral Vascular Accident	4 days
331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Arteriosclerosis	4 yrs
83a	(c)	Senility	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 17, 1949, to July 8, 1949, that I last saw the deceased alive on July 7, 1949, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

SIGNATURE Arthur F. Jones M.D. (Degree or title) ADDRESS 110 S. Centre St. DATE SIGNED July 9, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF July 11, 1949

NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. July 11, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md. ADDRESS

RECEIVED
JUL 15 1948
BUREAU F. S.

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

06358

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va. COUNTY Barbour
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 5 weeks	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Belington ~~5 yrs.~~
HOSPITAL OR INSTITUTION OR STREET ADDRESS 214 N.Mechanic St.	STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print)	(First) Rosie	(Middle) M.	(Last) Moore	4. DATE OF DEATH	(Month) July 6 (Day) (Year) 1949
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow	8. DATE OF BIRTH March 19-1876	9. AGE last birthday 73 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) BarbourCo.W.Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Bart Delughter		14. MOTHER'S MAIDEN NAME Debbie Phillips			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY No. -------	17. INFORMANT C.L.England (nephew)			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage (apoplexy)	3 Days
331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 83a	(b) Arteriosclerosis	?
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒*
21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒*, Inquiry ☒* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D.	H. V. Deming M.D.	Cumberland Md.	July 6-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 9, 1949	Fansler Cemetery	Hendricks, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 11, 1949	Winter R. Frantz, M.D.	Harry R. Greenlief,	Parsons, W. Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15A

RECEIVED
JUL 14 1949
BUREAU T. S.

Within corporate limits

06359

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 78 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS St Girard Ste.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) St Girard St

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) A. (Last) Mullan

4. DATE OF DEATH (Month) July (Day) 24 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Oct 21, 1870
9. AGE last birthday 78 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wm T Mullan
14. MOTHER'S MAIDEN NAME Anna B Carlos.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Bernard V. Mullan.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage	6 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterial hypertension	2 yrs
	(c)	

331
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 19, 1949, to July 24, 1949, that I last saw the deceased alive on July 24, 1949, and that death occurred at 7 P m., from the causes and on the date stated above.

SIGNATURE R. F. Pieraski, Jr. (Degree or title) ADDRESS Cumberland, Md DATE SIGNED July 25-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 26, 1949
NAME OF CEMETERY OR CREMATORY St Peter & Paul's
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. July 25, 1949
REGISTRAR'S SIGNATURE Walter R. Frantz M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06360

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport. LENGTH OF STAY (In this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 425 Walnut Street,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport.
STREET ADDRESS (If rural, give location) 425 Walnut Street.

3. NAME OF DECEASED (Type or Print): (First) Lawrence (Middle) A. (Last) Murphy.

4. DATE OF DEATH: (Month) July (Day) 26, (Year) 1949.19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 5, 1866.

9. AGE last birthday: 83 yrs. If under 1 year: Months 5 Days 21 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Piedmont, West Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Murphy.

14. MOTHER'S MAIDEN NAME: Mary Fleming.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Ross Baughman.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage and Hemiplegia left	Five Days
331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 83a	(b) Arteriosclerosis	Ten Years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 21, 1949, to July 26, 1949, that I last saw the deceased alive on July 26, 1949, and that death occurred at 4:05 P m., from the causes and on the date stated above.

SIGNATURE: Paul R. Wilson (Degree or title): M.D. ADDRESS: 111 Ashfield St. Piedmont, W.Va. DATE SIGNED: July 28, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: July 29, 1949.
NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery.
LOCATION (City, town, or county) (State): Westernport, Maryland.

DATE REC'D BY LOCAL REG.: July 28/49
REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: W. Harold Fredlock ADDRESS: Piedmont, West Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06361 4

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 34 Howard St.

3. NAME OF DECEASED (Type or Print): (First) Baby (Middle) Boy (Last) Neal
4. DATE OF DEATH: (Month) July (Day) 27, (Year) 1949

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: July 26, 1949
9. AGE last birthday: yrs. | If under 1 year: Months. | Days 1 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland, Cumberland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Enoch John Neal
14. MOTHER'S MAIDEN NAME: Hilda Catherine Alkire

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. | (If year, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Mrs. Enoch J. Neal

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) premature baby 5½ months — INTERVAL BETWEEN ONSET AND DEATH: 5½

776 Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-26, 1949, to 7-27, 1949, that I last saw the deceased alive on 7-26, 1949, and that death occurred at 7:20 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) C Mintz M.D. | ADDRESS 54 Green St. | DATE SIGNED 7-27-49

23. BURIAL, CREMATION, REMOVAL, (Specify) Burial | DATE July 29, 1949 | NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. July 29, 1949 | REGISTRAR'S SIGNATURE Walter K. Kantz, M.D. | 24. FUNERAL DIRECTOR John J. Hafer | ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06362

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, McCoole
LENGTH OF STAY (In this place): 9 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, McCoole
STREET ADDRESS (If rural, give location): 1 Mi. N. McCoole

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Cornelius	Alonzo	O'Haver	July	1	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	9/7/1894	54 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Watch Man	R. R.	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John O'Haver	Mary Darr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.	706-05-9372	Mrs. C. A. O'Haver

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Chronic Myocarditis (About Six Years)	At once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)		
(c)		

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H. V. Deming, M.D. H. V. Deming M.D.	Cumberland, Md.	7/1/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7/4/49	Philos	Westernport, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 1/49		Ellsworth S. Boal	Westernport, Md.

RECEIVED
JUL 5 1949
BUREAU V. S.

Within corporate limits

06363

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: In route to hospital — LENGTH OF STAY (in this place): 0
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cumberland Md. Memorial Hospital (write)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Pa. — COUNTY: Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Wellersburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Elmer (Middle) Arthur (Last) Petenbrink

4. DATE OF DEATH: (Month) July (Day) 6 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: April 23-1896

9. AGE last birthday: 53 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oiling foreman

10b. KIND OF BUSINESS OR INDUSTRY: machinery construction

11. BIRTHPLACE (State or foreign country): Sand Patch Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Petenbrink

14. MOTHER'S MAIDEN NAME: Flora Kennell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 194-03-2813

17. INFORMANT: Son) Donald Petenbrink)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Shock, due to abdominal hemorrhage, from a torn — about 1-3/4 hours.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b) left iliac vessel, which was due to a fracture of

812.8
1700

(c) the left ramus, ran over by a truck.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Savage River dam near Luke — (CITY OR TOWN): rural Garrett — (COUNTY): ~~Allegany~~ — (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): July 6-49 about 1.30 P m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? A truck backing, driver did not see him & ran over him.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. July 6-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: July 9, 1949 — NAME OF CEMETERY OR CREMATORY: White Oak Cemetery — LOCATION (City, town, or county) (State): Somerset County, Penna.

DATE REC'D BY LOCAL REG.: July 8, 1949 — REGISTRAR'S SIGNATURE: Walter R. Frantz M.D. — 24. FUNERAL DIRECTOR: Harvey A. Beigler, Hyndman, Penna. — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15A

RECEIVED
JUL 12 1949
BUREAU F. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: R.F.D.5 Cresaptown
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Potomac river, Brady's Rd. R.F.D.5 Cresaptown

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: R.F.D.5 Cresaptown
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Eva	Rema	Poland	July	2	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	married	Jan. 4-1924	25 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	--	Riverton Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lester Thompson	Maysell Dove

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		Raymond L. Poland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

975
1648

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Asphyxia due to drowning.	about 2 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Walked into Potomac river with suicide intent.	
	(c) Ill health	since puberty

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Constipation & dysmenorrhea

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐* CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	Potomac river	R.F.D.5 Cresaptown	Allegany	Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☒*	HOW DID INJURY OCCUR?
July 2/49-2.30 p.m.		Walked in Potomac River, suicide

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D.	H.V. Deming M.D.	Cumberland Md.	July 2-1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 5 1949	Hillcrest Cem.	Near Cumberland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 5, 1949	[illegible]	John J. Hofer	Cumberland, Md

RECEIVED
JUL 20 1949
BUREAU T. C.

DR. MURRAY

06365

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 6 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL	STREET ADDRESS (If rural, give location) 215 N. MECHANIC STREET

3. NAME OF DECEASED (Type or Print) (First) VIOLA (Middle) E (Last) PORTER

4. DATE OF DEATH (Month) JULY (Day) 14 (Year) 1949

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW

8. DATE OF BIRTH APRIL 13, 1880

9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HENRY REUSCHEIN

14. MOTHER'S MAIDEN NAME MARY MEISTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. — — —

17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH 10 months

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Uterine Polypus, Fibroid in Anemia

215 56b

(c) — Dual years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION July 9 49

19b. MAJOR FINDINGS OF OPERATION Rlayer Polypoid growth in anemia

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 4, 1949 to July 14, 1949, that I last saw the deceased alive on July 13, 1949, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

SIGNATURE F. A. G. Murray MD (Degree or title) ADDRESS Cumberland Md DATE SIGNED July 15 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF July 12, 1949

NAME OF CEMETERY OR CREMATORY St. Luke's Cem.

LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. July 16, 1949

REGISTRAR'S SIGNATURE Winter R Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumberland, Md.

M

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 19 1949
BUREAU OF S

M

Wilson

Within corporate limits

06366

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 6 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) Ft. Cumberland Hotel

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Angela Benedetti Purcell

4. DATE OF DEATH (Month) (Day) (Year) July 21 1949

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Jan. 25, 1864
9. AGE last birthday 85 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Leon ~~Lyon~~ Benedetti
14. MOTHER'S MAIDEN NAME Mary Dempsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. —
17. INFORMANT Mrs.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	6 Mos
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	10 yrs.
	(c)	

422.1
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7.17, 1949, to 7.21, 1949, that I last saw the deceased alive on 7.24, 1949, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE J. W. Gleason (Degree or title) ADDRESS 126 Yuconsh Cumberland Md DATE SIGNED 7/22/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 7-25-49
NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery
LOCATION (City, town, or county) Evanston (State) Ill

DATE REC'D BY LOCAL REG. July 22, 1949
REGISTRAR'S SIGNATURE Winter R Trantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
JUL 25 1949
BUREAU T. S.

Within corporate limits

06367

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 60 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 142 Independence Street	STREET ADDRESS (If rural, give location): 142 Independence Street

3. NAME OF DECEASED (Type or Print)	(First) George	(Middle) John	(Last) Reitmeier	4. DATE OF DEATH	(Month) July	(Day) 30	(Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: April 14 1877	9. AGE last birthday: 72 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crossing Watchman	10b. KIND OF BUSINESS OR INDUSTRY: B & O R R.	11. BIRTHPLACE (State or foreign country): Germany	12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME: Bartholomew Reitmeir	14. MOTHER'S MAIDEN NAME: Barbara Risinger						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY No.: 705-05-1477	17. INFORMANT: Mrs Ellen Reitmeier					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary Disease	hours.
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive C.V. Disease,	years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to July 30 1949, that I last saw the deceased alive on July 29, 1949, and that death occurred at 1:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

B. M. Schindler Mor 41 Greenleaf Cumberland Mar July 30, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Aug 1 1949	NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery	LOCATION (City, town, or county): Cumberland	(State): Maryland
DATE REC'D BY LOCAL REG.: Aug. 1, 1949	REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.	24. FUNERAL DIRECTOR: William H. Kight,	ADDRESS: Cumberland, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 4 1949
BUREAU V. S.

Within corporate limits

Durrett

06368

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 40 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 405 Furnace Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 405 Furnace St.

3. NAME OF DECEASED (Type or Print) (First) Howard (Middle) De Sales (Last) Riley

4. DATE OF DEATH (Month) July (Day) 29 (Year) 1949

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH April 6, 1890

9. AGE last birthday 59 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe repairman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Isiah Riley

14. MOTHER'S MAIDEN NAME Lydia Ann Keener

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 217-14-4355

17. INFORMANT Mrs. Howard Riley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary Thrombosis	Acute
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	5 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 28, 1949, to July 29, 1949, that I last saw the deceased alive on July 28, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Clark L. Lemon (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 7/30/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Aug. 1, 1949

NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery

LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. July 31, 1949

REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.

24. FUNERAL DIRECTOR John J. Hofer ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 4 1949
BUREAU V. S.

Evidence for addition in #18 shown on:

06369

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

FILM No. 6 121 AUG 23 1949

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg, Md.
LENGTH OF STAY (in this place) 3 Weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hancock
STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) (First) Bruce (Middle) Elmer (Last) Robinson

4. DATE OF DEATH (Month) 7 (Day) 9 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 4/8/1891
9. AGE last birthday 58 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orchard Helper
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Garrett County Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Andrews
14. MOTHER'S MAIDEN NAME Susan Blocher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 214-16-2726
17. INFORMANT Lela A. Robinson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

199.8 Immediate cause (a) Carcinoma of lungs & liver — 1 yr.

47d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — Primary site impossible to tell [8/22/49 alec]

(c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 21, 1949, to July 9, 1949, that I last saw the deceased alive on July 9, 1949, and that death occurred at 11 30 P m, from the causes and on the date stated above.

SIGNATURE W. C. Gattens (Degree or title) M.D. ADDRESS Frostburg, Md. DATE SIGNED 7/11/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 7/13/49
NAME OF CEMETERY OR CREMATORY St. Annes Cemetery
LOCATION (City, town, or county) Avilton (State) Md.

DATE REC'D BY LOCAL REG. 7-12-49
REGISTRAR'S SIGNATURE Mrs. Blanche O. Price Acting
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06370

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 70 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 111 Washington St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 111 Washington St.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) C. (Last) Roman

4. DATE OF DEATH: (Month) July (Day) 16 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Strike out all but one): Married

8. DATE OF BIRTH: April 30 '79

9. AGE last birthday: 70 yrs. If under 1 year: Months; If under 24 hrs.: Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Clark

14. MOTHER'S MAIDEN NAME: Margaret Gibson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs Hugh Fullerton. Wash. D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: Sudden

420.1 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — (CITY OR TOWN): — (COUNTY): — (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from ....., 19....., to 7-16, 1949, that I last saw the deceased alive on 7-14, 1949, and that death occurred at 12:17 p.m., from the causes and on the date stated above.

SIGNATURE: C C Zimmerman (Degree or title) M.D. ADDRESS: Cumberland Md. DATE SIGNED: 7-18-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: July 19 49 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: July 18, 1949 — REGISTRAR'S SIGNATURE: Hunter R Brady M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: Cumberland

VS. A15

Within corporate limits

DR. W.F.WMS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06371

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 214 SARATOGA ST.,

3. NAME OF DECEASED (Typo or Print): (First) ILDA (Middle) T. (Last) SCHAFER

4. DATE OF DEATH: (Month) July (Day) 5 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: APR. 28 1893

9. AGE last birthday: 56 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

11. BIRTHPLACE (State or foreign country): MARYLAND Cumberland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: WILLIAM E. TURNER

14. MOTHER'S MAIDEN NAME: MARY L. FECHTIG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — From July 1,

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

331 83a (c) Cerebral Arteriosclerosis (Marked)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1.30. 1947 to July 5 1949, that I last saw the deceased alive on July 5 1949, and that death occurred at 9:50 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

F. W. Williams Cumberland 7-5-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county) (State)
Burial	July 7 1949	St. Lukes Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 7, 1949	Winter L. Lantz, M.D.	William H. Kight	Cumberland, Md.

RECEIVED
JUL 12 1949
BUREAU V. S.

Within corporate limits

06372

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 21 da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland (Rural)
STREET ADDRESS (If rural, give location) RFD #3 Bedford Rd

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) M. (Last) Seibert
4. DATE OF DEATH (Month) July (Day) 25 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Jan 12, 1866
9. AGE last birthday 83 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Springfield W. Va
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Harry Orndoff
14. MOTHER'S MAIDEN NAME Everette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Chas. Taylor

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial failure	Mrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	Unknown
	(c)	

450.0
97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1949, to July, 1949, that I last saw the deceased alive on July 25, 1949, and that death occurred at 10:25 a.m., from the causes and on the date stated above.

SIGNATURE D. T. Rees (Degree or title) M.D. ADDRESS 404 Decatur St DATE SIGNED 7/26/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 27, 1949
NAME OF CEMETERY OR CREMATORY Greenmount Cemetery
LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. July 27, 1949
REGISTRAR'S SIGNATURE Walter K. Lantz M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 2 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06373

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg; LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Midlothian; STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) ANNA ELIZABETH (Middle) (Last) SKIDMORE

4. DATE OF DEATH: (Month) July (Day) 25 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 2-29-1912

9. AGE last birthday: 37 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Williams

14. MOTHER'S MAIDEN NAME: Jemima Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Edgar Skidmore, Midlothian, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hemorrhage and Shock. — 5 Hrs.

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

670.6 146a

(b) Placenta Praevia, (8 months Pregnant)

(c) Secondary anemia.

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: (14 Pregnancies at age 37).

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-23, 1949, to 7-25, 1949, that I last saw the deceased alive on 7-25, 1949, and that death occurred at 4:50 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. C. Diehl, M.D. Frostburg, Md 7/26/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 7-27-1949 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 7-27-49 — REGISTRAR'S SIGNATURE: Mrs. Harvey A. Roe

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

RECEIVED
JUL 29 1949
BUREAU T. S.

M

06374

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 35 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary	STREET ADDRESS (If rural, give location) Furnace St.

3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) W.	(Last) Starrett	4. DATE OF DEATH	(Month) July	(Day) 14	(Year) 1949
6. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH Dec. 25, 1864	9. AGE last birthday 84 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY K-S Tire	11. BIRTHPLACE (State or foreign country) Wheeling, W. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John W. Starrett	14. MOTHER'S MAIDEN NAME Margaret Smith						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 220-10-0140	17. INFORMANT Daughter					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremic Poisoning	6 wks
442 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio Vascular Renal Disease	3 yrs
131a	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 19, 1949, to July 14, 1949, that I last saw the deceased alive on July 14, 1949, and that death occurred at 11 15 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	July 15, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 16, 1949	St. Lukes Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 16, 1949	Winter R. Frantz M.D.	John J. Hofer,	Cumberland, Md.

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 15 1913
BUREAU P. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4 — 16375

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The occupation is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural
LENGTH OF STAY (In this place): 15 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cumberland Country Club

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 710 Hill Top Drive

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Harry	D.	Stearn	July	29	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Sept. 3-1898	50 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dist. Mgr. of the Darnell	Theater Chain	Rome N.Y.	U.S.A.

13. FATHER'S NAME: Oliver Stearn
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	141-07-2563	Geo. R. Light

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — at once

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D.	H.V. Deming M.D.	Cumberland Md.	July 29-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Aug 1 49	St Marys Burial Park	Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 1, 1949	Walter L. Lantz M.D.	Louis Stein Inc	Cumberland

VS. A15A

RECEIVED
AUG 4 1949
BUREAU V. S.

Within corporate limits

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Within corporate limits

06376

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 38 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 520 Beall Street

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Oscar (Last) Summers
4. DATE OF DEATH (Month) 7 (Day) 8 (Year) 1949
5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH June 18 1869
9. AGE last birthday 80 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor
10b. KIND OF BUSINESS OR INDUSTRY Retired R.R.
11. BIRTHPLACE (State or foreign country) W. Va.
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME William Summers
14. MOTHER'S MAIDEN NAME Mary Ellen Metcalf
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Dau.-Mrs. Young

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hepatitis	1 mo
157 46g Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma head of pancreas (clinical diagnosis)	4 mo
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 25, 1949, to July 8, 1949, that I last saw the deceased alive on July 7, 1949, and that death occurred at 4:24 a.m., from the causes and on the date stated above.

SIGNATURE Arthur F. Jones M.D. (Degree or title) ADDRESS 110 S. Centre St. DATE SIGNED July 9, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF July 11 1949
NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery
LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. July 9, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR William H. Kight, ADDRESS Cumberland, Md.

RECEIVED
JUL 19 1949
BUREAU F. S.

Within corporate limits

DR. HODGES.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06377

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MARYLAND | LENGTH OF STAY (In this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DEER PARK
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) OLIN (Middle) M. (Last) TASKER

4. DATE OF DEATH: (Month) JULY (Day) 25 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: AUG. 28, 1905

9. AGE last birthday: 43 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND Fitzmiller

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN A. WILSON

14. MOTHER'S MAIDEN NAME: MINNIE PAUGH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

642.1 Immediate cause (a) Chronic Nephritis - Hypertension ? 7 Mos

148b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pregnancy - full term - delivered at home 7/17/49.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bedfast 7 weeks - fractured ankle.

19a. DATE OF OPERATION: None | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 24 1949 to July 25 1949, that I last saw the deceased alive on July 25 1949, and that death occurred at 5:50 P.m., from the causes and on the date stated above. 7/25/49

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. Royce Hodges, M.D. Cumberland, Md

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: July 27 1949 | NAME OF CEMETERY OR CREMATORY: Tasker Cemetery | LOCATION (City, town, or county) (State): Near Deer Park, Maryland

DATE REC'D BY LOCAL REG.: July 27, 1949 | REGISTRAR'S SIGNATURE: Hunter R. Frantz, M.D. | 24. FUNERAL DIRECTOR: Embry Bolden, Oakland, Maryland | ADDRESS

VS. A15

RECEIVED
AUG 2 1949
BUREAU V. S.

Within corporate limits Dr. Hodges

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Within corporate limits

CERTIFICATE OF DEATH

06378

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (In this place) [redacted] Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE [redacted] Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 632 Elm Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	E.	Valentine	July	9	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	March 20, 1914	35 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own home	Cumberland, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Bernard Beakly	Anna K~~eifer~~ Kieffner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		214-07-0923	MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Brain abscess (occipital lobe)	?
191 53 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Sarcoma scalp (occipital reg)	1 1/2 yrs.
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prolonged x-ray therapy

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1948	Spindle sarcoma	Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19 48, to July 9, 19 49, that I last saw the deceased alive on July 9, 19 49, and that death occurred at 4 50 p.m. from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
W. Royce Hodges, M.D.	Cumberland, Md.	7/9/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7/12/49	Hillcrest Burial Park	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 12, 1949	Walter K. Mantz, M.D.	John J. Hafer,	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M I T

VS. A15

RECEIVED
JUL 19 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06379

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 46 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural, give location) 1031 Bedford St.

3. NAME OF DECEASED (Type or Print) (First) Walter (Middle) Maxwell (Last) Valentine
4. DATE OF DEATH (Month) July (Day) 6 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower
8. DATE OF BIRTH Aug. 24-1902
9. AGE last birthday 46 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shovel operator
10b. KIND OF BUSINESS OR INDUSTRY Road Bldg.
11. BIRTHPLACE (State or foreign country) Cumberland Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lorenzo Valentine
14. MOTHER'S MAIDEN NAME Mattie Brant
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-8612
17. INFORMANT Mrs. Mattie Brant Valentine

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	about 5 days
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. H. V. Deming M.D. (Degree or title) ADDRESS Cumberland Md. DATE SIGNED July 6--1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF july 8/49
NAME OF CEMETERY OR CREMATORY Zion Memorial Park
LOCATION (City, town, or county) Cumberland (State) Md.
DATE REC'D BY LOCAL REG. 7-8-49
REGISTRAR'S SIGNATURE Winter R Trantz, M.D.
24. FUNERAL DIRECTOR John J Hafer, Cumberland, Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06381

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 51 Ormand St.

3. NAME OF DECEASED (Type or Print): (First) FLORENCE (Middle) HENRIETTA (Last) WILLIAMS

4. DATE OF DEATH: (Month) July (Day) 2, (Year) 19 49

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 11-23-1864

9. AGE last birthday: 84 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jocob Betz

14. MOTHER'S MAIDEN NAME: Phillipi Heintz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Gertrude Williams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chr Myocarditis — Interval Between Onset and Death: 12 years

422.2 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1937, 19..., to July 2, 1949, that I last saw the deceased alive on July 1, 1949, and that death occurred at 2:30 A. m., from the causes and on the date stated above.

SIGNATURE: Wm C Lane — (Degree or title): MD — ADDRESS: Frostburg Md — DATE SIGNED: 7-4-49

23. BURIAL, CREMATION REMOVAL, (Specify): burial — DATE THEREOF: 7-4-49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 7/3/49 — REGISTRAR'S SIGNATURE: Mrs. B. O. Price — Acting L.

24. FUNERAL DIRECTOR: J. R. Durst, — ADDRESS: Frostburg, Md.

RECEIVED
JUL 6 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06381

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Queen City Hotel

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Pa. — COUNTY: Beaver
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baden
STREET ADDRESS (If rural, give location): 506 Bryan Ave ✓

3. NAME OF DECEASED (Type or Print): (First) Edward (Middle) W. (Last) Wilson
4. DATE OF DEATH: (Month) July (Day) 24 (Year) 1949

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug. 5-1920
9. AGE last birthday: 28 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student, Vet. Adm.
10b. KIND OF BUSINESS OR INDUSTRY: Butcher
11. BIRTHPLACE (State or foreign country): Cleveland Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Wilson
14. MOTHER'S MAIDEN NAME: Eva Lease

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 2
16. SOCIAL SECURITY NO.: 193-10-9617
17. INFORMANT: papers in suitcase

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH: about 15 hours.

Immediate cause (a) Contusion of brain with cerebral edema

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Fell in hotel room, striking head against
(c) some object.

909.6
1860

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Queen City Hotel (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY: July 24-49- 3:20 A m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Fell in hotel room striking head against some object.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. July 25-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: July 28, 1949
NAME OF CEMETERY OR CREMATORY: Sylvania Hills
LOCATION (City, town, or county) (State): Rochester, Penna.

DATE REC'D BY LOCAL REG.: July 25, 1949
REGISTRAR'S SIGNATURE: Winter K. Hantz, M. D.
24. FUNERAL DIRECTOR: Hartzell Funeral Home, Rochester, Penna.
ADDRESS

RECEIVED
AUG 2 1949
BUREAU V. S.

06382

MARYLAND STATE DEPARTMENT OF HEALTH

Within corporate limits

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 2 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural, give location): 426 Race St.

3. NAME OF DECEASED (Type or Print): (First) Martha (Middle) E. (Last) Witt

4. DATE OF DEATH: (Month) July (Day) 15 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Seperated

8. DATE OF BIRTH: April 6-1901

9. AGE last birthday: 48 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook-B&O R.Ry.Y.M.C.A.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stephen E. Knotts

14. MOTHER'S MAIDEN NAME: Marietta Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: — — —

17. INFORMANT: Chart, from Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Subarachnoid hemorrhage	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerosis	?
330 8300	(c) also had hypertention	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V.Deming M.D. H.V. Deming M.D. ADDRESS: Cumberland Md. DATE SIGNED: July 15-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: July 17, 1949

NAME OF CEMETERY OR CREMATORY: Mt. Herman Cem.

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: July 17 1949

REGISTRAR'S SIGNATURE: Hunter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc. ADDRESS: Cumberland Md

RECEIVED
JUL 19 1949
BUREAU T. S.

Within corporate limits

DR.W.F.WMS.

06383

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. LENGTH OF STAY (In this place) 27 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS CUMBERLAND, MD. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 544 FAIRVIEW AVE.,

3. NAME OF DECEASED (Type or Print) (First) ANNIE (Middle) (Last) WOERNER
4. DATE OF DEATH (Month) July (Day) 18 (Year) 1949

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED
8. DATE OF BIRTH MAR. 3 1875
9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME FREDERICK SOETHE
14. MOTHER'S MAIDEN NAME ANNIE LOTZE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of urinary bladder — 6 Months

181 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

52b (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-10-1949, to 7-18-1949, that I last saw the deceased alive on 7-18-1949 and that death occurred at 11:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
J. W. F. Williams MD Cumberland 7-19-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 7/21/49
NAME OF CEMETERY OR CREMATORY Fox Hill Cemetery
LOCATION (City, town, or county) Cumberland, (State) Md

DATE REC'D BY LOCAL REG. July 20, 1949
REGISTRAR'S SIGNATURE Winter R. Trantz, M.D.
24. FUNERAL DIRECTOR Alvin P. Right ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 26 1949
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06384

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 45 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 700 Gephart Drive

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 700 Gephart Drive

3. NAME OF DECEASED (Type or Print): (First) Kinsey (Middle) A. (Last) Wolfe

4. DATE OF DEATH: (Month) July (Day) 10 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Mar. 15-1887

9. AGE last birthday: 62 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. of Textile Enj.

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Martinsburg W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob H. Wolfe

14. MOTHER'S MAIDEN NAME: Emma M. Creque

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 214-07-4028

17. INFORMANT: K. Albert Wolfe (son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditinns, if any, giving rise to the above cause stating the underiying cause last	(b) coronary sclerosis	?
	(c)	

420.1
940

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☐, *Inspection* ☒, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE: H.V. Deming M.D. H.V. Deming M.D.
(Degree or title)
ADDRESS: Cumberland Md.
DATE SIGNED: July 10-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: July 12, 1949
NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: July 12, 1949
REGISTRAR'S SIGNATURE: Winter K. Brantz M.D.
24. FUNERAL DIRECTOR: Charles L. George
ADDRESS: Cumberland Md

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